

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare East Orlando		STREET ADDRESS, CITY, STATE, ZIP CODE 250 South Chickasaw Trail Orlando, FL 32825	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51234</p> <p>Based on interview, and record review, the facility failed to provide evidence that an abuse allegation was thoroughly investigated for 1 of 3 residents reviewed for abuse, of a total sample of 3 residents, (#3).</p> <p>Findings:</p> <p>Review of resident #3's medical record revealed an annual Minimum Data Set, dated dated dated [DATE] which indicated a Brief Interview for Mental Status score of 9 out of 15, mild to moderate cognitive impairment.</p> <p>On 10/30/24 at 12:30 PM, resident #3 was in her room alert and oriented to herself and place. She recalled an incident that occurred sometime in the past month or two when she reported to staff that a male staff member was rough with her. She was unable to recall who she had told or other details about what happened afterwards.</p> <p>On 10/31/24 at 8:00 AM, the Nightshift Supervisor stated he could recall, a couple of weeks ago resident #3 reported a staff person, whom she described as Certified Nursing Assistant (CNA) A, was rough with her. He said he did not ask resident #3 to explain what she meant by the word rough or to clarify any details of the alleged incident. The Nightshift Supervisor said he did not do a skin assessment for resident #3 at the time of the allegation. He said he did not direct resident #3's assigned female nurse, Registered Nurse (RN) A to do a skin assessment at the time of the allegation either. He said he put the paperwork he completed about resident #3's abuse allegation under the Risk Manager's office door at the end of his shift at approximately 7:00 AM.</p> <p>On 10/31/24 at 11:00 AM, the Risk Manager concurrently reviewed the investigation statements provided by facility staff persons, CNA A, CNA B, RN A, and the Nightshift Supervisor. She verified that resident #3's abuse allegation occurred on 10/23/24 and acknowledged there was no evidence of the time when resident #3's abuse allegation was made to the Nightshift Supervisor, or when the alleged incident occurred. The Risk Manager acknowledged they did not have evidence of verifying with the Nightshift Supervisor, RN A, CNA A, or CNA B regarding the time resident #3's alleged abuse incident occurred, or why the Nightshift Supervisor failed to immediately initiate any investigation into the alleged abuse incident. The Risk Manager did not say how the facility would be able to report any allegations in the required timeframe if they did not know what time the alleged abuse allegation was made.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105783	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare East Orlando		STREET ADDRESS, CITY, STATE, ZIP CODE 250 South Chickasaw Trail Orlando, FL 32825	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy titled Resident Mistreatment, Neglect, and Abuse Prohibition Guidelines most current revision date 1/24/23 indicated that all employees were required to immediately report suspected instances of abuse to their supervisor, Abuse Coordinator, Administrator, and/or Director of Nursing so that the facility could protect the residents and promptly investigate the occurrence. If the alleged violation involved abuse the State Agency, Adult Protective Services, and local law enforcement must be reported to within two hours of the alleged violation.</p>		